Conclusion: A large proportion of children underwent surgery which revealed, histologically, a non-inflamed appendix. Discrepancies remain between intra-operative and histological findings, with implications for those arguing for increased use of 'laparoscopy & proceed' techniques. Poor adherence to hospital antibiotic protocol was noted.

0389: WHEN DOES ULTRASOUND INFLUENCE MANAGEMENT IN SUSPECTED CASES OF PAEDIATRIC APPENDICITIS? A RETROSPECTIVE DUAL CENTRED STUDY BETWEEN CHRISTCHURCH PUBLIC HOSPITAL IN NEW ZEALAND AND ROYAL ABERDEEN CHILDREN'S HOSPITAL IN SCOTLAND

Duncan S.G. Scrimgeour [1], Christopher Driver [1], Sebastian King [2], Spencer Beasley [2]. [1] *Royal Aberdeen Children's Hospital, Aberdeen, UK;* [2] *Christchurch Public Hospital, Christchurch, New Zealand*

Ultrasound (US) is a safe imaging modality used for assessing patients with abdominal pain but its use in the management of acute appendicitis is contentious.
Aim: To review the role of US in the management of suspected appendicitis in two similarly matched hospitals.
Methods: Data from acute admissions, radiology and theatre were cross-referenced to review all children <16 years of age that underwent an appendicectomy ± an US for query appendicitis in 2009.
Results: The number of US scans performed were similar between the two centres (108/442 NZ and 30/157 Aberdeen). Girls were more likely to be scanned than boys (Chi^2=0.038). The visualisation rate(VR) of the appendix at US was 32% in NZ and 17% in Aberdeen with identical Positive Predictive Value(67%), Negative Predictive Value(100%) and positive appendicectomy rate(73%) in both institutions. Combined, 28%(13/46) had an appendicectomy when the appendix was not seen at US and no other pathology was detected, of which 54% were confirmed cases of appendicitis.
Conclusion: We should be encouraging radiologists to look for the appendix. VR is much poorer than literature suggests. If US-negative, have a high threshold for appendicectomy. If US-positive this aids laboratory results and clinical suspicion. What is the role of a diagnostic laparoscopy?

0613: CRYING OUT FOR A DRINK: COMPLIANCE WITH NATIONAL PRE-OPERATIVE FASTING GUIDELINES IN CHILDREN

Stephani Bernard, Alexander Macdonald, Jianli Samantha Goh, Niyi Ade-Ajayi. *King's College Hospital, London, UK*

Aim: Appropriate pre-operative fasting in children is crucial to minimise risk of aspiration. However, over zealous fasting may adversely affect recovery as well as increasing parent and child anxiety. Children admitted for elective surgery are often initially clerked on general paediatric wards by paediatric juniors. This may result in incorrect pre-operative fasting. We set out to audit practice against national guidelines.
Method: A questionnaire survey was undertaken of surgeons, paediatricians and nursing staff involved in the care of children (birth to 16yrs) from 5 surgical sub-specialties (general, neurosurgery, OMFS, orthopaedic and transplant) on both general paediatric and sub-specialty specific wards. Statistical analysis for variation with $p < 0.05$ accepted as significant.
Results: 43 individuals were surveyed (19 doctors [8 surgical, 11 paediatric], 24 nurses). 35% had full awareness of fasting guidelines and there was no statistically significant difference between staff groups. Knowledge of specific fasting times for formula and breast milk was poor compared with those for solids and clear fluids (p=0.002).
Conclusions: Current awareness of paediatric pre-operative fasting guidelines is poor particularly those regarding formula and breast milk and thus pertaining to younger infants. This is concerning as this group is particularly susceptible to pre-operative distress when fasted incorrectly.

1113: HERNIOTOMY IN CHILDREN – LONG TERM FOLLOW UP

Bhavani Sidhartha Mothe, Magdi Hanafy. *Leighton General Hospital, Crewe, Cheshire, UK*

Aims: Inguinal hernia repair is the most commonly performed surgical procedure in children. Recent data suggests this operation in children carries a very low complication and recurrence rates. This study was carried out to evaluate the long term recurrence rates.
Methods: Retrospective study of patient notes from 2000 - 2009(below 16yrs). Data collected via telephone interview/questionnaire from patient & parents as appropriate. Follow up time calculated by subtracting age at operation from current age
Results: 71 of 85 patients were able to provide required data (14 months - 14 years). 33 out of 71 (46.4%) were below 5 yrs, further 27/71 (38%) were above 5 years of age. Median follow up was 7 years with a minimum follow up of at least 1 year. 3 patients (4.2%) developed recurrence at 1, 3 & 4 years from their initial operation. 1 child (1.2%) developed hematoma and wound infection post-operatively.
Conclusions: Hernia surgery in children is associated with very low complications and long term follow up study suggests most recurrences occur within 5 years of original operation. Our study suggests recurrence is more common in above 2 year old repairs. Although this is a small study it opens a debate whether this group needs long term follow up or not.

PLASTIC SURGERY

0037: BREAKING DOWN THE HEALTH CARE LANGUAGE BARRIER: EXPERIENCE OF A REGIONAL BURN UNIT

Thet Su Win, Mark Sheldon Lloyd, Mozaffor Hosain, Peter Dziewulski, Odhran Shelley. *St Andrew's Centre for Burns and Plastic Surgery, Chelmsford, UK*

Aims: The objectives of this study were to (1) assess the requirement and provision of translation service at a regional burn unit (2) to implement changes based on national guidelines to improve clinical effectiveness.
Method: A prospective study was performed to assess translation requirements of 100 patients attending the burns outpatients department. A questionnaire was designed to collect data on burn distribution, mechanism, complications, native language of patient and person accompanying patient, translation needs and adequacy. Changes were implemented according to the NICE guidelines, including updating translation materials, training interpreters, educating referring hospitals, contacting twenty cultural centres in the region to provide 'burns first aid and safety in the home' courses in the native community language. Follow-up study collected data on 85 additional patients following implementation of changes.
Results: The number of patients whose native language is not English in the two cohorts was similar (32%vs30.5%). Translation needs decreased significantly (32%vs8%; p<0.0001) following education to the referring hospitals. Adequacy of translation improved (91.6%vs100%), and the use of ad hoc interpreters, including family members/relatives and staff, reduced.
Conclusions: Targeted education can improve language service, which is an essential element of patient care in a multi-cultural society such as Britain.

0063: THE TERTIARY MANAGEMENT OF PRETIBIAL LACERATIONS

Marc-James Hallam, Steven Lo, Shona Smith, Tania Cubison. *Queen Victoria Hospital, East Grinstead, UK*

Aims: Pretibial lacerations remain one of the commonest yet most neglected conditions facing plastic surgey. Furthermore, these injuries afflict the most vulnerable groups of adults - the elderly and the infirm. This review aims to provide an evidence-based treatment plan, reduce unnecessary surgery and safeguard the at-risk patient.
Methods: A MEDLINE search was conducted using the terms (Lacerations OR Laceration) and keywords (pretibial, pre ADJ tibial) to identify high level evidence.
Results: We present an evidence-based approach of these injuries and propose a treatment algorithm that we have utilized to successfully manage 40% of pretibial lacerations conservatively.
Conclusion: The evidence-based algorithm suggested for the management of these wounds is- **I Linear laceration without skin loss:** Manage conservatively; Level of Evidence IV. II Flap laceration viable: Steristrip and manage conservatively; level of Evidence I. **III Flap laceration non-viable**: Small non-viable flaps: Excise and manage conservatively; larger skin flaps: Excise and skin graft under local anaesthetic; level of Evidence II. IV Skin loss: < 1% TBSA: Manage conservatively; >1% TBSA: Skin graft under local anaesthetic; level of Evidence V. V Laceration with haematoma: Evacuate haematoma and skin graft; Level of Evidence V